MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-e)

10462

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 100 Penn Ave

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 22 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 100 Penn. Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John William Bankert

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary Stultz

6(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Aug. 10 - 1902

8. AGE:

Years	Months	Days	If less than one day
38	2	6	____ hrs. ____ min.

9. Birthplace Westminster Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Edward O. Bankert

13. Birthplace Mt. Pleasant Carroll Co. Md.

MOTHER 14. Maiden name Lydia Ann Bumiller

15. Birthplace Union Mills Carroll Co. Md.

16. Informant Leonard R Bankert

Address Silver Run Carroll Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19-1940 (month) (day) (year)

Cemetery or crematory Krider's Cem.

Location N. Westminster Md.

18. Funeral director H Bankard & Son

Address Westminster Md.

19. 10/17 1940 L Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16th 1940, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14th 1940, to Oct 16 1940, and that I last saw him alive on Oct 15 1940.

	CAUSE	DURATION
Immediate cause of death	Coronary Heart Disease	
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J Stewart M. D. or other

Address Westminster Md. Date signed Oct 17 1940

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

10463

Reg. Dist. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs Emma L. Benner

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife: Dr C. M. Benner

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 3, 1871

8. AGE:

Years	Months	Days	If less than one day
69	8	13	hrs. min.

9. Birthplace: Penna
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Amos Basehoar

13. Birthplace: Penna

MOTHER — 14. Maiden name: Catherine M. Shelly

15. Birthplace: Md

16. Informant: Dr. C. M. Benner

Address: Taneytown, Md

17. Burial (Burial, cremation, or removal) Date thereof: Oct 19-40 (month) (day) (year)

Cemetery or crematory: Lutheran

Location: Taneytown Md

18. Funeral director: C. O. Bussard & Son

Address: Taneytown, Md.

19. Oct 17 1940 (Date rec'd by registrar) Ethel M. Mehring Registrar, Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1940, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1940, to Oct 16 1940, and that I last saw her alive on Oct 16 1940.

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. N. Legg M. D. or other

Address: Mission Bridge Date signed: 10-17-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10464

74

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 4 months, 21 days

Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Chapel Hill Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: ERNEST GEORGE BOLDEN

3. (b) Social Security Number: None

4. Sex: male

5. Color or race: colored

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 6, 1922

8. AGE: Years: 18 Months: 6 Days: 1 If less than one day: hrs. min.

9. Birthplace: Chapel Hill, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER 12. Name: Joseph Bolden

13. Birthplace: Unknown

MOTHER 14. Maiden name: Gertrude Hansen

15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 11, 1940 (month) (day) (year)

Cemetery or crematory: Chapel Hill, Md.

Location: Prince George Co.

18. Funeral director: John T. Rhines & Co.

Address: 901-3rd St. S.W.

19. October 7 19 40 (Date rec'd by registrar) Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7th. 1940, at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6th. 1940 to October 7 1940 and that I last saw h- im alive on October 7th. 1940.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	March 1940
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 10/7/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 23 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10465

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1102 North Stricker St.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: MINNIE LEE BROWN

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Otis Brown
6.(c) If alive, give age: 25 years
7. Birth date of deceased (mo., day, yr.): January 6, 1917

8. AGE: Years	Months	Days	If less than one day
23	9	27	....hrs. ....min.

9. Birthplace: Cordel, Georgia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown
12. Name of father: Robert Hamilton
13. Birthplace of father: Georgia
14. Maiden name of mother: Bertha Tumor
15. Birthplace of mother: Pinehurst, Georgia
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland
17. ~~Not C~~ Burial (Burial, cremation, or removal. Which?) Date thereof 10/6/194 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: A. A. County
18. Funeral director: Walter B Spriggs
Address: 139 W Hamburg St
19. October 3 19 40 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3 1940, at 11:20A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 23rd. 1940, to October 3rd 1940
and that I last saw her alive on October 3rd. 1940

Immediate cause of death: Tuberculous Peritonitis — DURATION: May 1940
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings of operations: --
Date of op.: --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 10/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
NOV 4 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10466

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sandymount (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 70 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Sandymount Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William H. Brown

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Eliza Shriver

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28. 1850

8. AGE: Years 90 | Months 2 | Days | If less than one day hrs. min.

9. Birthplace Woodsboro, Frederick Co. Md. (Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER 12. Name George Hall Brown

13. Birthplace Maryland

MOTHER 14. Maiden name

15. Birthplace

16. Informant Mrs Bradley Brown

Address Westminster, Md. RD #4

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31. 1940 (month) (day) (year)

Cemetery or crematory Sandymount Cem.

Location Sandymount, Carroll Co. Md.

18. Funeral director H Bankard & Son

Address Westminster Md.

19. 10/30 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28th 1940, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 26th 1940 to Oct. 28th 1940, and that I last saw h— alive on Oct. 25th 1940.

Immediate cause of death Chronic Myocarditis DURATION

Due to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. F. Billingslea M. D. or other

Address Westminster, Md. Date signed 10/28/40

RECEIVED
NOV 5 1940
BUREAU V. S.

10467

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster Rural Near
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
County home
Stay in hospital or inst. (yrs., or mos., or days) 8 years
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Alfred E. Bruce

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Widowed

6 (b) Name of husband or wife Ida Smith
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 - 1864

8. AGE:

Years	Months	Days	If less than one day
76	5	20	hrs. min.

9. Birthplace Westminster Carroll Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Alfred Bruce
13. Birthplace Maryland

MOTHER
14. Maiden name Angeline Bell
15. Birthplace Maryland

16. Informant Thomas W. Bruce
Address Washington Rd. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25: 1940 (month) (day) (year)
Cemetery or crematory Ellsworth Cem.
Location Nr. Westminster, Md.

18. Funeral director H. Bankard Son
Address Westminster, Md.

19. 10/24/1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22-46 1940 at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 1940, to 10-22 1940, and that I last saw him alive on 10-17- 1940.

Immediate cause of death	DURATION
Arteriosclerosis	15 yrs.
Due to Acute Coronary	
Due to Cardiac Dilatation	3 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Yes
Of autopsy Yes

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Shoop M. D. or other
Address Westminster Md. Date signed 10-23-46

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

10468

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 29 Washington Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 42 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 29 Washington Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Dora Bowen Bruce

3. (b) Social Security Number None

4. Sex F.
5. Color or race colored
6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband ~~of wife~~ Thomas W. Bruce
6. (c) If alive, give age about 70 years

7. Birth date of deceased (mo., day, yr.) April 14 1878

8. AGE: Years 62 Months 5 Days 24 If less than one day ____ hrs. ____ min.

9. Birthplace Union Bridge, Carroll Co. Md. (Town, county and state)
10. Usual occupation House servant
11. Industry or business

FATHER
12. Name X Bowen
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Mary Bowen
15. Birthplace Carroll Co. Md.

16. Informant Ruth Bruce
Address 29 Wash. Ave. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 11 40 (month) (day) (year)
Cemetery or crematory Ellsworth Cem.
Location Westminster Md.
18. Funeral director J. E. Myers, Jr.
Address Westminster, Md.

19. 10 5 19 40 Registrar
(Date recd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 8 - 1940, at 8:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug - 1930 to Oct 6 1940, and that I last saw h alive on Oct 8 - 1940.

	DURATION
Immediate cause of death Hypertension Chr. Myocarditis	
Due to Chr Nephritis	
Due to Acute dilatation of heart	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D.
M. D. or other
Address Westminster Md. Date signed 10-9-40

RECEIVED
NOV 5 1940

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10469

Reg. Dist. No. 76

(50)

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 56 Carroll St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 8 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 56 Carroll St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Myrtle Buckingham
3. (b) Social Security Number: none

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harbert A. Buckingham
6(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): March 16, 1889
8. AGE: Years 51 Months 7 Days 10 If less than one day ___ hrs. ___ min.
9. Birthplace: Carroll County, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER
12. Name: Jesse L. Stoner
13. Birthplace: Maryland
MOTHER
14. Maiden name: Rebecca Bush
15. Birthplace: Maryland
16. Informant: Herbert A. Buckingham
Address: Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/28/40 (month) (day) (year)
Cemetery or crematory: Sandy Mount
Location: Sandyville, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 10/28 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26, 1940, at 6 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940 to Oct 26 1940, and that I last saw her alive on Oct 25 1940.
Immediate cause of death: Carcinoma of brain met. from Carcinoma of breast.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. C. Jennette M.D. or other
Address: Westminster Md. Date signed: 10-27-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10470

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 2 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 8 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1303 North Fremont Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: LE ROY BUDD

3. (b) Social Security Number: 213-14-5457

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 9, 1917

8. AGE: Years	Months	Days	If less than one day
22	9	24	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business: Unknown

FATHER
12. Name: Charles Budd
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Martha Scott
15. Birthplace: Baltimore, Maryland

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 5 1940 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore City
18. Funeral director: Geo. S. Kelson
Address: 1303 Presstman St

19. October 3 1940 (Date rec'd by registrar) Albert R. Swanckhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 3rd, 1940 at 9:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1, 1940 to October 3 1940
and that I last saw h im alive on October 3 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 1940
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings of operations: --
Date of op. --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of --
Where did injury occur? --
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 10/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 4 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

CERTIFICATE OF DEATH

10471

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos, 7 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 3 mos, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 E. Oliver St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SAMUEL EMERSON CONWAY

3.(b) Social Security Number: 220-07-4009

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21, 1901

8. AGE: Years	Months	Days	If less than one day
39	2	27	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Cleaned Cars

11. Industry or business: Unknown

FATHER

12. Name: George Conway

13. Birthplace: Baltimore, Maryland

MOTHER

14. Maiden name: Agnes ?

15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D;

Address: Henryton, Maryland

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 10-21-40 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem.

Location: Balto., Md.

18. Funeral director: Joseph D. Locke, Jr.

Address: 1364 N. Central Ave.

19. October 18 19 40 (Date rec'd by registrar) Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 19 40, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11, 19 40 to Oct. 18 19 40 and that I last saw him alive on October 18 19 40

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 10/18/40

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OCT 24 1940
BUREAU V S

10472

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-L

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days; life in Carroll Co.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town ~~Sykesville~~ Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Main Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ~~[illegible]~~ Mrs. Cordelya Cook

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Charles Cook

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1884

8. AGE:

Years	Months	Days	If less than one day
55	10	26	hrs. min.

9. Birthplace Delight, Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name ~~Unknown~~ Wm Hann
13. Birthplace ~~Unknown~~ Maryland

MOTHER
14. Maiden name Sara Shipley
15. Birthplace Carroll Co. Maryland

16. Informant Hospital record.

Address

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Oct. 15, 1940
(month) (day) (year)

Cemetery or crematory Pipe Creek

Location M. New Windsor - Md.

18. Funeral director C. M. Waltz

Address Winfield Md

19. Oct 18 1940
(Date rec'd by registrar)

Johnny Weaver
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1940, at 11.45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 23 1940, to Oct. 12 1940 and that I last saw her alive on Oct. 11 1940

Immediate cause of death	DURATION
arteriosclerotic & hypertensive heart disease	Unknown
Due to arteriosclerosis & hypertension	Unknown
Due to	
Other conditions Renal insufficiency	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lewis Danziger, M.D.
M. D. or other

Address Sykesville, Md. Date signed 10-12-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 4 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10473

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 2mos, 20 days
Stay in this community (yrs., or mos., or days): same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 525 W. Lanvale St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: EDWARD DAVIS

3. (b) Social Security Number: 212-05-3270

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	married

6 (b) Name of husband or wife: Florence Davis
6(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): March 18, 1901

8. AGE: Years	Months	Days	If less than one day
39	6	13	hrs. min.

9. Birthplace: Laurance, South Carolina
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown
FATHER 12. Name: James Davis
13. Birthplace: South Carolina
MOTHER 14. Maiden name: Carrie Irby
15. Birthplace: South Carolina
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 5, 1940 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Balto Md
18. Funeral director: Mrs Katie R Williams
Address: 322 N Schroeder St
19. Oct. 1 1940 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1st. 1940, at 3:40 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11th. 1940, to Oct. 1st. 1940 and that I last saw him alive on October 1 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1st. 1940
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)
Major findings:
Of operations --
Of autopsy --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 10/1/40

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OCT 25 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

10474

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Winfield
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 11 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll.

City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R. D. Woodbine
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Ethel R. Davis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6 (b) Name of husband ~~or wife~~: Murray R. Davis

6(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Dec. 12. 1899

8. AGE:

Years	Months	Days	If less than one day
40	9	28	____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland.
(Town, county, and state)

10. Usual occupation: Home wife.

11. Industry or business

FATHER
12. Name: Harvey E. Pickett
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Florence L. Conaway
15. Birthplace: Maryland.

16. Informant: Mr. Murray R. Davis

Address: R.D. Woodbine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 12, 1940 (month) (day) (year)

Cemetery or crematory: Bethel Church Grd Cem

Location: near Winfield. Md.

18. Funeral director: C. M. Waltz

Address: Winfield. Md.

19. Oct 12 1940 (Date rec'd by registrar) Edna M. Hewitt (Registrar)
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 10, 1940, at 7:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1940 to October 8 1940, and that I last saw h er alive on October 8 1940.

Immediate cause of death	DURATION
Carcinomatosis	5 mos.
Due to: Cancer of breasts	10 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Cancer of right breast.

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob R. Jensen M.D.
M. D. or other

Address: Sykesville, Md. Date signed: Oct 10, 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

EXCHANGE
NOV 5 1940
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10475
Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos., 13 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 8 mos, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 259 Roberts St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MILES DEAN

3.(b) Social Security Number: 214-16-5025

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mable Dean
6.(c) If alive, give age: unknown years
7. Birth date of deceased (mo., day, yr.): June 28, 1899

8. AGE: Years 41 | Months 3 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace: Palestine, Texas (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: Unknown
FATHER
12. Name: Dea Dean
13. Birthplace: Unknown
MOTHER
14. Maiden name: Emma Gaston
15. Birthplace: Palestine, Texas
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct 19 40 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Baltimore
18. Funeral director: Geo. G. Kelson
Address: 1303 Presstman St.
19. October 15 19 40 (Date rec'd by registrar) Albert R. Swackhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15, 1940 19 ..., at 2:20 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2, 19 40, to October 15 19 40
and that I last saw him alive on October 15 19 40

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1939
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Superintendent Henryton, Maryland Date signed: 10/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 4 1940
BUREAU V. S.

10476

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:
County Carroll
City or town Ridgeville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Mt Airy Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Roland Thomas Dotson

3. (b) Social Security Number 212-14-7118

4. Sex M
5. Color or race C
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Martha Dotson
6(c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) July 27 1902
8. AGE: Years 38 Months 2 Days 9 If less than one day hrs. min.
9. Birthplace Howard Co. Md.
(Town, county, and state)
10. Usual occupation labor
11. Industry or business
FATHER
12. Name Isaac Dotson
13. Birthplace Carroll Co. Md.
MOTHER
14. Maiden name Emma Dotson
15. Birthplace unknown
16. Informant Martha Dotson
Address Mt. Airy Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 16 1940 (month) (day) (year)
Cemetery or crematory Fairview
Location near Taylorsville
18. Funeral director H. M. Snyder
Address Mt. Airy Md.
19. Oct. 15 1940 Wm D Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1940, at 11 P M Prior to
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —,
and that I last saw h — alive on — 19 —.
Immediate cause of death Strangulation by hanging (Suicide)
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 10/13/40
Where did injury occur? Mr Mt Airy (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury Hanging Injured at work?

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner
M. D. or other
Address New Windsor Md Date signed 10/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 7 1940
BUREAU S. S.

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10477

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 7 mo's, 6 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Nanticoke (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Margaret Anna Elsey

3.(b) Social Security Number: —

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elmer Elsey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 15, 1905

8. AGE: Years: 35 Months: 6 Days: 5 If less than one day ..... hrs. ..... min.

9. Birthplace: Nanticoke, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Winfield Garrison
13. Birthplace: Nanticoke, Md.

MOTHER
14. Maiden name: Ada Wallace
15. Birthplace: Nanticoke, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 23 40 (month) (day) (year)

Cemetery or crematory: Nanticoke

Location: Nanticoke, Maryland

18. Funeral director: David K Messick

Address: Helrom Md.

19. 10/20 1940 (Date rec'd by registrar) Albert R. Swankham Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20, 1940, at 3.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1940, to October 20, 1940 and that I last saw her alive on October 20, 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1933

Due to: ---

Due to: ---

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ---- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed

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NOV 4 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

10478

Reg. Dist. No. 72.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

1. PLACE OF DEATH:

County Carroll

City or town Union Mills

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 25 Years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster, Md. R.D. 1 Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John William Benton Flickinger

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Martha M (Yeiser) Flickinger

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan. 18. 1870

8. AGE: Years 70 | Months 8 | Days 22 | If less than one day ____ hrs. ____ min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name William H Flickinger

FATHER 13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Maria Shuler

MOTHER 15. Birthplace Maryland.

16. Informant Irvin E. Flickinger

Address Westminster Md. R.D. #4

17. Burial Date thereof Oct. 13. 1940 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery (Union)

Location Silver Run, Md.

18. Funeral director J. M. Fink & Son.

Address Littlestown R.F.D. Pa.

19. Oct. 11th. 1940 (Date rec'd by registrar) Calvin E. Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1940, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10 1939, to Oct. 10 1940, and that I last saw h- alive on Oct. 10 1940.

	DURATION
Immediate cause of death Congestive Heart Failure	
Due to Arteriosclerosis	
Due to Mitral Insufficiency	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Milton A. Katz M.D. M.D. or other

Address Westminster Date signed Oct 11

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NOV 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10479

74

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 9 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 7 months, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1362 N. Calhoun St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: ORA FRAZIER

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Samuel Frazier

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): April 12, 1900

8. AGE:

Years	Months	Days	If less than one day
40	6	4	..... hrs. ..... min.

9. Birthplace: Lancaster, Virginia (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER

12. Name: James Bascar

13. Birthplace: Lancaster, Virginia

MOTHER

14. Maiden name: Lucy Ball

15. Birthplace: Lancaster, Virginia

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: Oct. 18 40 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: Geo. G. Kelbon

Address: 1303 Prentiss St.

19. October 16 19 40 (Date rec'd by registrar) Albert R. Swankbam Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16, 1940 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1940, to October 16, 1940 and that I last saw her alive on October 16, 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec., 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.

Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 10/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10480

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos, 21 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 512 Roberts St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROBERT THOMAS GEARY

3.(b) Social Security Number: 218-01-2055

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Alzenia Geary
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): April 12, 1908

8. AGE: Years	Months	Days	If less than one day
32	6	6	....hrs. ....min.

9. Birthplace: Jackson, North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: Richard Geary
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Lilly Smith
15. Birthplace: Jackson, North Carolina

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland

17. Interment (Burial, cremation, or removal. Which?) Date thereof Oct. 22 1940 (month) (day) (year)
Cemetery or crematory: Edlestons Mem. Pk. Marysburg, Md
Location: Edlestons, Md. " "

18. Funeral director: Mrs. Geo. H. Haverd
Address: 1631 Druid Hill ave.

19. October 18 1940 (Date rec'd by registrar) Albert R. Swanbeam Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 19 40, at 4:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 19 40, to Oct. 18 19 40 and that I last saw h... alive on October 18 19 40

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1940
Due to: ----	
Due to: ----	
Other conditions: ----	

(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op.:
Autopsy results: ----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

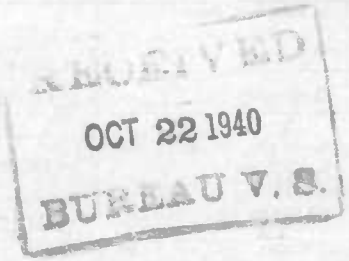
23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 10/18/40

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CHANGE OF BURIAL PLACE: taken from Burial permit 10/23/40 L



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10481

Reg. Diat. No. 74

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 128 N. Jonathan Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
Rose Griffith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Hubert Griffith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 17, 1892

8. AGE: Years	Months	Days	If less than one day
48	3	13	hrs. min.

9. Birthplace: Hagerstown, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: ----

FATHER
12. Name: William Orcutt
13. Birthplace: U. S.

MOTHER
14. Maiden name: Myrtle Trider
15. Birthplace: U. S.

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 2 1940 (month) (day) (year)
Cemetery or crematory: Hagerstown Cemetery
Location: Hagerstown, Md.
18. Funeral director: Wm. H. Bast & Sons
Address: Boonsboro, Md.

19. Oct. 31 1940 (Date rec'd by registrar) C. Harry Weil Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30th 1940, at 12 Mid-night

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 1940, to Oct. 30 1940 and that I last saw her alive on October 30 1940

Immediate cause of death	DURATION
Meningo encephalitis	Since
Due to: Syphilis	1935
Due to:	
Other conditions: Left sided hemiplegia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Alan Jacklar, M.D. M. D. or other
Address: Springfield State Hosp. Date signed 10/31/40

RECEIVED
NOV 4 1940
BUREAU V. S.

10482

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural Near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 82 - 7

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural Near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Samuel A. Grunholtz

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Emma B. Riegle

6(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) March 10 - 1858

8. AGE: Years 82 Months 7 Days . If less than one day ___ hrs. ___ min.

9. Birthplace New Windsor Carroll Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name John Grunholtz
13. Birthplace Maryland

MOTHER
14. Maiden name Lydia Stone
15. Birthplace Maryland

16. Informant Mrs John Beard

Address Westminster, Md.

17. Burial Kinder Date thereof Oct. 12 1940
(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory ~~Westminster~~ Cemetery

Location Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 10/11 1940 L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1940, at 3:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 1940, to Oct 10 1940, and that I last saw him alive on Oct 9 1940.

Immediate cause of death Cardio Vascular Renal Disease

Due to Arterio Sclerosis

Due to Senility.

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Md Date signed Oct 11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

10483

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs., 6 mos., 2 days.
Hospital, institution, or street address where death occurred: Springfield State Hospital.
How long in hospital or institution? 6 yrs., 6 mos., 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2511 Aisquith
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Hardecker.

3.(b) Social Security Number #

4. Sex: Male.
5. Color or race: White.
6.(a) Single, married, widowed, or divorced: Widowed.
6.(b) Name of ~~husband or~~ wife: Mary Bauerschmidt.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 3, 1859.

8. AGE: Years 81. Months 3. Days 15. If less than one day ..... hrs. ..... min.

8. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business: Gas and Electric Co.
FATHER
12. Name: George Hardecker.
13. Birthplace: Germany.
MOTHER
14. Maiden name: Barbara Russ.
15. Birthplace: Germany.
16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 21, 1940 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cem.
Location: Balto. Md.
18. Funeral director: Wm Cook
Address: 1217 St Paul St. Balto Md.
19. Oct. 18 1940 (Date rec'd by registrar) C. Harry Wew Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1940, at 10:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938 to Oct. 18, 1940.
and that I last saw him alive on Oct. 18, 1940.

	DURATION
Immediate cause of death: Acute Lobar Pneumonia	1 day.
Due to: Pulmonary Hypostasis	2 days.
Due to: Myocardial Degeneration about	1 year.

Other conditions: Psychosis with Cerebral Arteriosclerosis prior to 4-16-34.
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Harry F. Baer, M.D. M. D. or other
Address Sykesville, Md. Date signed 10-18-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 24 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46B) ✓

10484

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown Rural Near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 32

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town near Taneytown Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Clarence Edward Harver

3. (b) Social Security Number none

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced married

6 (b) Name of ~~husband~~ or wife Sadie Ann Utz

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April 12 1878

8. AGE: Years 62 Months 6 Days If less than one day ___ hrs. ___ min.

9. Birthplace Frizelburg, Carroll Co. - Maryland
(Town, county, and state)

10. Usual occupation Cattle Dealer

11. Industry or business

FATHER
12. Name Frederick Harver
13. Birthplace Maryland

MOTHER
14. Maiden name Fannie M. Lapoff
15. Birthplace Maryland

16. Informant Mrs Henry Stone

Address New Windsor Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Oct. 15. 1940
(month) (day) (year)

Cemetery or crematory Piney Creek Cem.

Location Mt. Harney Carroll Co. Md.

18. Funeral director H Bankard Son

Address Westminster Md.

19. Oct. 14. 1940 Ethele M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12th 1940, at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30th 1940, to Oct 12th 1940, and that I last saw him alive on Oct 12th 1940.

Immediate cause of death Carcinoma of Stomach

DURATION 3 mo.

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner MD
M. D. or other

Address Taneytown Md Date signed Oct 12th 1940

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10485

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. White Oak
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: ROBERT HENRY JOHNSON

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): April 11, 1915

8. AGE: Years	Months	Days	If less than one day
25	5	23	... hrs. ... min.

9. Birthplace: White Oak, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: Andrew Johnson
13. Birthplace: Charles County, Maryland

MOTHER
14. Maiden name: Frances Matthews
15. Birthplace: White Oak, Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial, cremation, or removal. Which? Burial Date thereof: Oct 7 1940 (month) (day) (year)
Cemetery or crematory: Good Hope
Location: Colesville Md
18. Funeral director: Robert L Snouder
Address: Rockville Md

19. (Date rec'd by registrar) October 4th 1940
Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4th. 1940 at 2:00 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 27th. 1940 to October 4 1940 and that I last saw h... im alive on October 4th. 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1940
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings of operations: -- Date of op.: --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 10/4/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10486

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and giva nearest town)

Street No. 826 Carey Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LOUISE TRUEHEART KING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Elias King

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years	Months	Days	If less than one day
62	?	?	....hrs. ....min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER — 12. Name: George Johnson

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Malinda Hicks

MOTHER — 15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D. Address: Henryton, Maryland

17. Mt. Auburn Burial (Burial, cremation, or removal. Which?) Date thereof 10/10/40 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem.

Location: Balto. Md.

18. Funeral director: Joseph G. Locke, Jr.

Address: 1364 N. Central Ave.

19. October 7 1940 (Date rec'd by registrar) Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1940, at 6:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7th. 1940, to October 7 1940 and that I last saw her alive on October 7th. 1940

	DURATION
Immediate cause of death: Diabetic gangrene	Aug. 1940
Due to: Diabetes Mellitus	June '40
Due to: --	
Other conditions: Pulmonary tuberculosis	Apr. '40

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 10/7/40

VS A45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 11 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10487

(94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Taneytown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Annie E. Knox

3. (b) Social Security Number non

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife Wm H Knox

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 86 | Months 4 | Days 19 | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Hard work

11. Industry or business

FATHER 12. Name Emanuel Lambert

13. Birthplace Md

MOTHER 14. Maiden name Catherine Kepart

15. Birthplace Md

16. Informant Mrs Ellen Reiser

Address Taneytown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31 1940 (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown Md

18. Funeral director C O Fuss & Son

Address Taneytown

19. Oct 30 1940 (Date rec'd by registrar) Registrar Ethel M Mehring

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1940 19 , at 10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1935 to Oct 28, 1940, and that I last saw her alive on Oct. 28 1940

Immediate cause of death	Coronary Thrombosis	5 hours
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis D. Reindollar M. D. or other

Address Taneytown, Maryland Date signed Oct 30 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10488

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster (Rural)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution: Route #4
Stay in hospital or Inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Route #4
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Nancy Lee Lambert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) September 27, 1940

8. AGE: Years | Months | Days: 7 | If less than one day: — hrs. — min.

9. Birthplace Westminster, Carroll, Maryland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Edward Augustus Lambert
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Mary Elizabeth Wetzel
15. Birthplace Frederick Co. Md.

16. Informant Mr. Edward Lambert
Address Westminster, Md. Route #4

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5, 1940 (month) (day) (year)

Cemetery or crematory Western Cemetery
Location New Windsor

18. Funeral director D. Hartzler & Son
Address New Windsor

19. Oct 4 1940 (Date rec'd by registrar) C. Fogle Registrar
Dep Local

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1940, at 4:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1940, to October 3 1940, and that I last saw her alive on October 2 1940.

	DURATION
Immediate cause of death Unknown	
Due to Premature birth 7 months or less	
Due to Unknown causes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) —
Means of Injury — Injured at work?

23. SIGNATURE E. Reese Wilkens, M.D.
M. D. or other
Address 58 W. Main St. Westminster Date signed Oct 5 1940

West Windsor
Union Bridge

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10489

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Neavitt,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Talbot Co., Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John William Larrimore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nellie Lee
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 11, 1865

8. AGE: Years	Months	Days	If less than one day
74	10	20	____ hrs. ____ min.

9. Birthplace: Talbot County, Maryland (Town, county, and state)
10. Usual occupation: Retired waterman
11. Industry or business: -----

FATHER
12. Name: Theodore Larrimore
13. Birthplace: Maryland

MOTHER
14. Maiden name: Frances Holland
15. Birthplace: Maryland

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2, 1940 (month) (day) (year)
Cemetery or crematory: Neavitt Cemetery
Location: Neavitt, Md.
18. Funeral director: John O. Mitchell
Address: 100 Eutaw Place

19. Oct. 31 1940 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 1940 at 8:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16 1940 to Oct. 31 1940 and that I last saw h im alive on October 30 1940

Immediate cause of death	DURATION
Chronic Endocarditis;	
Chronic Myocarditis; generalized arteriosclerosis	3 yrs. minimum
Due to:	
Due to: Senility	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Alan Jacobs M. D. or other
Address: Springfield State Hosp. Date signed: 10/31/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
U. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

10490

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll.

City or town: Rural m. Warfieldsburg.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll.

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.D. Westminster, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: John T. Logue

3. (b) Social Security Number: No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 24, 1861

8. AGE:

Years	Months	Days	If less than one day
79	5	27	____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER
12. Name: Richard Logue
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Prudie Williams
15. Birthplace: Maryland.

16. Informant: Mr. Joshua Logue
Address: Westminster Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct. 20, 1940
(month) (day) (year)

Cemetery or crematory: Deer Park

Location: Smallwood, Md

18. Funeral director: C. M. Waltz

Address: Winfield Md.

19. 10/19 1940 (Date rec'd by registrar) L. Mandelwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18, 1940, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 1940, to Oct 18 1940, and that I last saw him alive on Oct 18 1940.

Immediate cause of death: Cerebral Hemorrhage

Due to: Arteriosclerosis (General)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. Glenn Speicher
M. D. or other

Address: Westminster Md. Date signed: Oct 19

RECEIVED
NOV 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10491

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 23 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Estelle Long

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm. H. Long

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 25, ? 1877

8. AGE:	Years	Months	Days	If less than one day
	? 62	9	10	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: John F. Reilly

13. Birthplace: Md.

MOTHER

14. Maiden name: Catherine Mullinix

15. Birthplace: Md.

16. Informant: Annie Mallon

Address: 1022 Brentwood Ave., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 8-1940 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Balto Md

18. Funeral director: Geo L Beyer Jr

Address: 1512 Hollins St Balto Md

19. Oct 5 1940 (Date rec'd by registrar) Catharine Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5, 1940 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1940, to Oct. 5, 1940 and that I last saw her alive on Oct. 5, 1940

	DURATION
Immediate cause of death: Bronchopneumonia	24 days
Due to: Arteriosclerotic heart disease	Known 4 mos.
Due to: Generalized arteriosclerosis	4 mos.
Due to: Chronic lymphangitis of rt. leg	35 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 10-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 8 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10492

83a

1. PLACE OF DEATH

County CARROLL Registration Dist. No. 83

Village or City BERRETT DISTRICT No. WOODBINE P.O. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Frederick Marshall Lowman

(a) Residence: No. BERETT DISTRICT WOODBINE St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Colored.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) October 10, 1907

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33		3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Laborer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farm

10. Date deceased last worked at this occupation (month and year) Oct 11, 1940

11. Total time (years) spent in this occupation 16

12. BIRTHPLACE (city or town) Berrett District
(State or country) Carroll County

FATHER

13. NAME John Lowman

14. BIRTHPLACE (city or town) Berett District
(State or country) Carrol County

MOTHER

15. MAIDEN NAME Fannie Berry

16. BIRTHPLACE (city or town) Woods mills
(State or country) Howard County

17. INFORMANT James W Lowman
(Address) Sykesville Md

18. BURIAL, CREMATION, OR REMOVAL
Place White Rock Cem. Date Oct. 16, 1940

19. UNDERTAKER C. M. Waltz
(Address) Winfield Md

20. FILED Oct 15, 1940 Edna M. Hewitt
Registrar.
Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October 13, 1940
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1940, to Oct 13, 1940

I last saw him alive on Oct 13, 1940; death is said to have occurred on tha date stated above, at 3 P m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage	2 days

Other Contributory Causes of importance:

Arteriosclerosis

Name of operation Deta of

Whet test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accidant, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Jacob R. Jensen M. D.

(Address) Sykesville, Md.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED OCT 21 19[illegible] BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10493

30-t

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Unknown

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 101 S. Culver Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

MICHAEL LYNCH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margaret Lynch

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): June 5, 1886

8. AGE: Years	Months	Days	If less than one day
54	4	22	....hrs. ....min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Florist + gardener

11. Industry or business: Shop

FATHER

12. Name: Michael Lynch

13. Birthplace: Ireland

MOTHER

14. Maiden name: Bridget Healey

15. Birthplace: Ireland

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30-40 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Balto. Md.

18. Funeral director: George A. Farley

Address: Fulton Ave & Fayette St. Balto.

19. Oct. 27 1940 (Date rec'd by registrar) C. Harry Weaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 27 1940, at 5:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8 1940, to Oct. 27 1940

and that I last saw him alive on Oct. 26 1940

Immediate cause of death	DURATION
Meningo-encephalitis	Over 3 yrs
Due to: Syphilis	Over 3 yrs
Due to:	
Other conditions: Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lewis Dunajon M.D. M. D. or other

Address: Sykesville, Md. Date signed: 10-27-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

10494

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs., 6 mos., 0 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital,
How long in hospital or institution? 25 yrs., 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland, County
City or town Baltimore,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1008 Appleton Street:
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William P. Magness.

3.(b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Divorced.

6.(b) Name of ~~husband or~~ wife Unknown.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4, 1877.

8. AGE: Years	Months	Days	If less than one day
63.	3.	5.	..... hrs. ..... min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual occupation Lineman, United R.R.
11. Industry or business
FATHER 12. Name Elijah Magness.
13. Birthplace Phila., Pa.
MOTHER 14. Maiden name Unknown. Mary Myers.
15. Birthplace Phila., Pa.
16. Informant Springfield State Hospital Records.
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12-1940 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Frederick ave Baltimore Md.
18. Funeral director George W. Little
Address 2900 Edmondson Ave.
19. Oct 10 1940 (Date rec'd by registrar) Harry F. Baer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1940, at 7 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1936 to Oct. 9, 1940
and that I last saw h.im alive on Oct. 9, 1940

Immediate cause of death	DURATION
Cerebral Embolism	One day.
Due to Chronic Endocarditis	5 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D.,
M. D. or other
Address Sykesville, Md. Date signed 10-9-40.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 14 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10495

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 5 days

Stay in this community (yrs., or mos., or days): 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Cambridge Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: AGNES CATHERINE MARINE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December 12, 1917

8. AGE:

Years	Months	Days	If less than one day
22	10	0	____ hrs. ____ min.

9. Birthplace: Cambridge, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER — 12. Name: Charles Marine

FATHER — 13. Birthplace: Cambridge, Maryland

MOTHER — 14. Maiden name: Addie Jolly

MOTHER — 15. Birthplace: Cambridge, Maryland

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15 1940 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Cambridge Md

18. Funeral director: Lewis H Blackburn

Address: Cambridge Md

19. October 12 19 40 (Date rec'd by registrar) Albert R. Goodhart Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12th. 19 40, at 8:25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7th. 19 40, to October 12 19 40, and that I last saw her alive on October 12th. 19 40

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1940
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Superintendent

Address: Henryton, Maryland Date signed: 10/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

10496

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A46

1. PLACE OF DEATH:

County Carroll

City or town Tyrone (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 70 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Carroll

City or town Tyrone Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Ida E. Marquette

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife John Marquette

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1864

8. AGE: Years	Months	Days	If less than one day
76	5	1	hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER 12. Name David F. Phillips

13. Birthplace Pa

MOTHER 14. Maiden name Louisa Worley

15. Birthplace Md.

16. Informant Harry Marqueete

Address Westminster, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 25, 1940 (month) (day) (year)

Cemetery or crematory Baust

Location Nr. Tyrone, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Oct 25 1940 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1940, at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1940, to Oct 23 1940, and that I last saw her alive on Oct 22 1940

Immediate cause of death	DURATION
Peritonitis, acute	
Due to Stuff of Gall bladder	
Due to gall stone block	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M. D. or other

Address Union Mills Date signed 10-23-40

RECEIVED
NOV 6 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10497

74

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 5 mos, 5 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 331 S. Fremont St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DOROTHY MAY MC INTYRE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 30, 1933

8. AGE: Years	Months	Days	If less than one day
7	6	15	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: Unknown

FATHER — 12. Name: Almie Mc Intyre

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Katie Mc Millian

15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof 10/19/40 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Baltimore Md

18. Funeral director: Miss D. T. Hemsley

Address: 578 W Biddle

19. 10/15 1940 (Date rec'd by registrar) Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15, 1940, at 3:25 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 10th. 1938, to October 15 1940

and that I last saw her alive on October 15th. 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1937

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? --

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.

M. D. or other

Address: Henryton, Maryland Date signed: 10/7/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 28 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-D) ✓

CERTIFICATE OF DEATH

Reg. Dist. No. 83 (10498)

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Woodbine, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 66 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Woodbine Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R. F. D.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Harry S. Owings

3. (b) Social Security Number: No.

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name ~~of husband~~ or wife: Myra L. Owings

6(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): April 10 1873

8. AGE: Years: 67 Months: 5 Days: 22 If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland.
(Town, county, and state)

10. Usual occupation: Cashier

11. Industry or business: Woodbine National Bank.

FATHER
12. Name: Altin Owings
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Margie Plummer
15. Birthplace: Maryland.

16. Informant: Mrs. Myra L. Owings

Address: R. D. Woodbine Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct. 4, 1940 (month) (day) (year)

Cemetery or crematory: Morgan Chapel

Location: near Woodbine Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield Md

19. Oct 3 1940 (Date rec'd by registrar) Edna M. Hewitt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 2, 1940, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 2 1940, to Oct 2 1940, and that I last saw him alive on Oct 2 1940.

Immediate cause of death: Carcinoma of Right Lung with Metaplasia to Liver

DURATION: 2 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. M. Van Poole M. D. ~~or other~~

Address: Mt Airy Md Date signed: 10/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

NOV 5 1940
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-d

10499

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs., 6 mos., 8 days.
Hospital, Institution, or street address where death occurred: Springfield State Hospital.
How long in hospital or institution? 27 yrs., 6 mos., 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Montgomery.
City or town: Unknown.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jesse M. Parker.

3.(b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): About 1872.

8. AGE: Years	Months	Days	If less than one day
68 (?).	Unk.	Unk.	hrs. min.

9. Birthplace: Maryland (?) (Town, county, and state)
10. Usual occupation: Carpenter.
11. Industry or business:
FATHER — 12. Name: Unknown.
FATHER — 13. Birthplace: Unknown.
MOTHER — 14. Maiden name: Unknown.
MOTHER — 15. Birthplace: Unknown.
16. Informant: Springfield Hospital Records.
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 9 1940 (month) (day) (year)
Cemetery or crematory: Springfield Hosp.
Location: Sykesville Md.
18. Funeral director: C. A. Baer
Address: Sykesville Md.
19. Oct 6 1940 C. Nancy Baer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5, 1940, at 10.50 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 1, 1938 to Oct. 5, 1940. and that I last saw h... alive on Oct 5, 1940.

	DURATION
Immediate cause of death: Acute Cardiac Dilatation	20 minutes
Due to: Chronic Myocarditis	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D.
M. D. or other
Address: Sykesville, Md. Date signed 10-5-40.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 4 1940
BUREAU V. S.

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (M) (I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10500

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Fairmount Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6211 Homer St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME ROGER LEE PLATT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
17	?	?	hrs. min.

9. Birthplace: Fairmount Heights (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: Unknown

FATHER 12. Name: John Platt

13. Birthplace: Hampton, South Carolina

MOTHER 14. Maiden name: Viola Rivers

15. Birthplace: Georgia

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31 1940 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Washington D. C.

18. Funeral director: C. E. Johnson

Address: Annapolis

19. Oct. 26 1940 (Date rec'd by registrar) Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26th. 1940 at 8:00P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 21 1940, to October 26 1940

and that I last saw him alive on October 26 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1940

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Superintendent Henryton, Md. Date signed: 10/26/40

RECEIVED
NOV 4 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

10501

Reg. Diat. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 yrs., 1 mo., 17 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 36 yrs., 1 mo., 17 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Baltimore City
State: Md. County: Carroll
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 918 Burgundy Alley
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Joseph Price

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) ? 1887

8. AGE:

Years	Months	Days	If less than one day
53			hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: ?
13. Birthplace: ?
MOTHER 14. Maiden name: Annie Price
15. Birthplace: ?
16. Informant: Hospital records.
Address: Sykesville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 22 1940 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cemetery
Location: Sykesville Md.
18. Funeral director: C. Harry Weer
Address: Sykesville Md.
19. Oct. 22 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 17, 1940, at 7:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 31, 1904, to Oct. 17, 1940
and that I last saw him alive on Oct. 17, 1940

Immediate cause of death	DURATION
Hypertensive cardio-vascular disease	? 1 yr.
Hypostatic bronchopneumonia	2 days.
Due to:	
Due to:	
Other conditions: Epilepsy	42 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph N. Marshall, M.D. M. D. or other
Address: Springfield State Hospital Date signed 10-17-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (306)

10502

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 10 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County none

City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2101 Maisel Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ROBERT RAEKE

3. (b) Social Security Number 216-07-7682

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Mildred Raeke

6.(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) April 18, 1904

8. AGE:

Years	Months	Days	If less than one day
36	6	6	hrs. min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)

10. Usual occupation Welder

11. Industry or business Fertilizer plant

FATHER
12. Name Charles Raeke
13. Birthplace U.S.A.

MOTHER
14. Maiden name Louise ?
15. Birthplace Unknown

16. Informant Hospital records

Address

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Oct 26-1940
(month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore - Md.

18. Funeral director John C. Miller Inc.

Address 2435 East Oliver St.

19. Oct. 24 1940
(Date rec'd by registrar)

C. Harry Weed
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1940, at 10.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1940, to Oct 24 1940 and that I last saw him alive on Oct. 24 1940

Immediate cause of death	DURATION
Meningo-encephalitis	Unknown
Due to Syphilis	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lewis Danziger M.D.
M. D. or other

Address Sykesville, Md. Date signed 10-24-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (114-d)

10593

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 year, 17 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Denton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: HAZEL AILEEN RICH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6 (b) Name of husband or wife: Douglas Rich
6(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): May 2, 1912

8. AGE: Years	Months	Days	If less than one day
28	5	28	hrs. min.

9. Birthplace: Denton, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Unknown

FATHER
12. Name: Charles Harris
13. Birthplace: Denton, Maryland

MOTHER
14. Maiden name: Ella Harris
15. Birthplace: Denton, Maryland

16. Informant: Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 3, 1940 (month) (day) (year)
Cemetery or crematory: Denton
Location: Denton, Maryland
18. Funeral director: J. Virgil Moore & Son
Address: Denton, Maryland

19. October 30 1940 (Date rec'd by registrar) Albert R. Swanbrow Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30, 1940 19 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13 19 40, to October 30, 19 40, and that I last saw her alive on October 30, 19 40

Immediate cause of death: not due to tuberculosis. Lung Abscess, since — DURATION: June, 1939.
Cause of lung abscess: Unknown. C.W.S.R.
Due to ---
Clinically, looked like tuberculosis. Reported upon
Due to sputum examinations failed to reveal tubercle bacilli. Health Department reports indicated that
Other conditions: no typical organisms predominated.

(Include pregnancy within 3 months of death)
Major findings:
Of operations: ----
Of autopsy: ---

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent
M. D. or other
Address: Henryton, Maryland Date signed 10/30/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 4 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10504

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 27 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 527 N. Fremont St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: BEATRICE ROBINSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: James Robinson

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): August 24, 1916

8. AGE: Years: 24 | Months: 1 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Chester, South Carolina (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Unknown

FATHER — 12. Name: Unknown

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Bertha Paden

15. Birthplace: South Carolina

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Removal Date thereof: Oct. 26-40 (month) (day) (year)

Cemetery or crematory: Concord M.E. Church C.

Location: Hilltop

18. Funeral director: Mrs Katie R Williams

Address: 702 N Schroeder St

19. October 18 1940 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18 1940, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1940, to October 18 1940 and that I last saw her alive on October 18 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Mar. 1940

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.: --

Autopsy results: --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Superintendent Henryton, Maryland Date signed: 10/18/40

RECEIVED
NOV 4 1940

10505

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John A. Rugemer

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Caroline Schneider

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): November 20, 1859

8. AGE: Years: 80 Months: 11 Days: 1 If less than one day: hrs. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Saloon keeper

11. Industry or business: Saloon

FATHER
12. Name: Joseph Rugemer
13. Birthplace: Germany

MOTHER
14. Maiden name: Barbara ?
15. Birthplace: Germany

16. Informant: Records Springfield State Hosp.

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 23-1940 (month) (day) (year)

Cemetery or crematory: Mount Carmel

Location: Odonnell St.

19. Funeral director: Lilly + Teeler INC.

Address: 403 S. Wolfe St.

19 Oct. 21 1940 (Date rec'd by registrar) A. Henry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21, 1940 19 at 6:30P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16 1940 to October 21 1940 and that I last saw him alive on October 21 1940

Immediate cause of death: Broncho pneumonia — DURATION: 24 hrs.

Due to

Due to: Senility

Other conditions: Chronic Myocarditis, Generalized Arteriosclerosis — Prior to adm.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Alan Jacobson, M.D. M. D. or other

Address: Springfield State H. Date signed: 10/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
BUREAU V. S.

10506

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2120 N. Pulaski St.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME

MEYER RUTKOWITZ

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Bessie Rutkowitz

B.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): ? ? 1882

8. AGE:

Years	Months	Days	If less than one day
58	?	?	..... hrs. ..... min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business

FATHER

12. Name: Gerson Rutkowitz

13. Birthplace: Russia

MOTHER

14. Maiden name: Mollie ?

15. Birthplace: Russia

16. Informant: Mrs. Bessie Rutkowitz

Address: 2120 N. Pulaski St. Balt. Md.

17. Burial (Burial, cremation, or removal Which?) Date thereof: Oct 13 - 1940 (month) (day) (year)

Cemetery or crematory: Hebrew Cemetery

Location: Baltimore, Md

18. Funeral director: Jack Lewis Inc

Address: 2100 Eutaw Place

19. Oct 12 1940 (Date rec'd by registrar) O. Harry Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 12 1940, at 6 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1940, to Oct 12 1940 and that I last saw him alive on Oct. 12 1940

Immediate cause of death: Cerebral vascular accident

Due to: Cerebral thrombosis

Due to: Hypertensive arteriosclerotic Heart disease

Other conditions

(Include pregnancy within 3 months of death)

DURATION
6 months
Unknown

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lewis Dunzigan M.D. M. D. or other

Address: Sykesville, Md Date signed: 10-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 19 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10507

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos, 5 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 3 mos, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1414 Harlem Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: BENJAMIN JOSEPH SMITH

3.(b) Social Security Number: 218-09-0905

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 25, 1914

8. AGE: Years	Months	Days	If less than one day
26	0	28	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Porter

11. Industry or business: Unknown

FATHER
12. Name: Benjamin Smith
13. Birthplace: Shady Side, Maryland

MOTHER
14. Maiden name: Elizabeth Foote
15. Birthplace: Baltimore, Maryland

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26 40 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Baltimore City

18. Funeral director: Isaiah D Brownson

Address: 1080 Montgomery Street

19. Oct. 23 19 40 (Date rec'd by registrar) Albert R Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23rd. 19 40, at 10:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18th. 19 40, to October 23 19 40 and that I last saw him alive on October 23 19 40

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1940
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury ---- Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Superintendent Henryton, Maryland Date signed: 10/18/40

RECEIVED
NOV 4 1940
M. BUREAU V. S.

10508

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-8)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 6 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1917 West Lafayette (If rural, give LOCATION)

2.(a) If veteran, name war: - - - - -

3.(a) FULL NAME Kendis ALBERT Sorrell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

8.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 10, 1906

8. AGE:

Years	Months	Days	If less than one day
34	4	0	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Albert Sorrell
13. Birthplace: Unknown BALTO MD

MOTHER
14. Maiden name: Ada Griswald
15. Birthplace: Unknown BALTO

16. Informant: Springfield Hospital Record

Address: Sykesville, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 10 14 40 (month) (day) (year)

Cemetery or crematory: LOUDON PARK

Location: BALTO MD

18. Funeral director: WM J TICKNER + SON

Address: NORTH + PA AVES

19. Oct 11 1940 (Date rec'd by registrar) A Harry Stone Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11, 1940, at 10:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5, 1940, to Oct. 11, 1940 and that I last saw him alive on Oct. 11, 1940

Immediate cause of death: Post-Encephalitic Syndrome (Parkinsonism). prior to

DURATION: 8-5-40

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

No autopsy - Pathologist absent.

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D., M. D. or other

Address: Sykesville, Md. Date signed: 10-11-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10509

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 14 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? (same as above)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 143 N. Jonathan St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Lillian Rideout (Washington)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 28, 1893

8. AGE:

Years	Months	Days	If less than one day
46	11	22	..... hrs. ..... min.

9. Birthplace: Hagerstown, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Annie Lee

15. Birthplace: Hope Hill, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland.

17. (Burial, cremation, or removal) Which? Date thereof: Oct - 23 - 40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md

18. Funeral director: J. H. Baldwin

Address: Hagerstown Md

19. 10/20/ 1940 Albert R. Swanhart Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20, 1940, at 10.25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6, 1940, to Oct. 20, 1940 and that I last saw her alive on October 20, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1939
Due to: ----	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op. .....

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ---- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Md. Date signed 10/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

10510
Reg. Dist. No. 5376

1. PLACE OF DEATH:
County Carroll
City or town Finksburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Rural near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Samuel Dorsey Webster

3. (b) Social Security Number

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Feb. 8 - 1880
8. AGE: Years 60 | Months 8 | Days 20 | If less than one day ____ hrs. ____ min.
9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name Charles E. Webster
13. Birthplace Maryland
MOTHER
14. Maiden name Caroline Bloom
15. Birthplace Maryland
16. Informant Sherman Bosley
Address Finksburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 (month) 30 (day) 1940 (year)
Cemetery or crematory Deerpark Cemetery
Location Smallwood, Carroll Co. Md.
18. Funeral director H Bankard & Son
Address Westminster, Md.
19. Oct. 28 1940 (Date rec'd by registrar) J. Frank Mellor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28/1940, at 6A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/26/1940, to 10/28/1940, and that I last saw him alive on 10/27/1940.

Immediate cause of death	DURATION
Myocarditis - Chronic (Decompensation)	6 mo
Due to Hypertension	10 yrs
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)
Major findings: —
Of operations
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE James G. Saffell M. D. or other
Address Reisterstown, Md. Date signed 10/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1940
BUREAU V. S.

10511

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 20 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 month, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1193 North Fulton Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Josephine J. Witt (Stefana J. Witkowski)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph Witt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 28, 1908

8. AGE:

Years	Months	Days	If less than one day
32	3	13	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -----

FATHER
12. Name: James Szablowski
13. Birthplace: Poland

MOTHER
14. Maiden name: Constance Pawlowska
15. Birthplace: Baltimore, Md.

16. Informant: Records of Springfield State Hospital, Sykesville, Md.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 13 1940 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: Balto Co. Md

18. Funeral director: Willis S. Fiackowski

Address: 2007, Eastern Ave

19. Oct. 11 1940 (Date rec'd by registrar) A. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1940, at 9:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 1940, to Oct. 10 1940 and that I last saw her alive on October 10 1940

Immediate cause of death	DURATION
Pulmonary tuberculosis	over 3 months
Due to	
Due to	
Other conditions: TBC of cecum & ileum	Unknown
Paranoid Schizophrenia	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Lewis Denziger, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 10-11-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10512

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: 13 yrs., 11 mos., 25 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution: 13 yrs., 11 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Sabillasville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Maude Workings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: -----

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 22, 1889

8. AGE: Years	Months	Days	If less than one day
50	9	18	..... hrs. ..... min.

9. Birthplace: Sabillasville, Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER

12. Name: John Workings

13. Birthplace: Maryland

MOTHER

14. Maiden name: Clara Alice Krise

15. Birthplace: Maryland

16. Informant: Records of Springfield State Hospital, Sykesville, Md.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12 1940 (month) (day) (year)

Cemetery or crematory Mt. Manata

Location Foxville, Md.

16. Funeral director M. L. Creager & Son

Address Thurmont Md.

19. Oct 10 1940 Affany Keen

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1940 at 12:05 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 20 1940 to Oct. 10 1940

and that I last saw her alive on October 9th 1940

Immediate cause of death: Pulmonary tuberculosis — DURATION: one 6 months

Due to:

Due to: Schizophrenia

Other conditions: Cattin & schizophrenia — 20 yrs

Peptic ulcer — 6 months

Peptic (Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lewis Danziger M.D. M. D. or other

Address: Sykesville, Md. Date signed: 10-10-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 4 1960
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122a)

CERTIFICATE OF DEATH

10513

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 13 Bond St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 86

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 13 Bond
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Theodore Parker Yingling

3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Amanda Routzahn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30. 1854

8. AGE: Years 86 Months 2 Days 1 If less than one day hrs. min.

9. Birthplace Westminster Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Sylvester Yingling
13. Birthplace Maryland

MOTHER
14. Maiden name Nancy Irvin
15. Birthplace Maryland

16. Informant Mrs Claude Buckingham

Address 13 Bond St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 2. 1940 (month) (day) (year)

Cemetery or crematory Meadowbranch Cem.

Location N. Westminster, Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 11/1 1940 (Date rec'd by registrar) F. Kevin Dunn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31st 1940, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1st 1940, to Oct 31st 1940, and that I last saw he was alive on Oct 31st 1940.

Immediate cause of death Strangulated Hernia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Wm. Stewart M. D. or other

Address Westminster Md. Date signed Oct 31st 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 5 1940
U. S.